RS-17 (rev 3-1-05)

Virginia Department of Rehabilitative Services
Technology Services Referral Form

Date: _____ DRS Case Number: _____

Client Information:

Name: Last _____ First _____ Middle I. _____

Street Address (or PO Box) _____

City _____ St _____ Zip _____

Phone (H) _____ (W) _____ (FAX) _____

(Cell) _____ Email _____

Programs *(select all that apply)* VR ☐ CRCMS ☐ Employee ☐

Disability: _____

Funding source(s) for AT/Mod: DRS VR ☐ CSF ☐ Workers' Comp ☐ CSB ☐ Self-pay ☐

Other ☐ Explain: _____

Name of Private Insurance: _____

Name of Policy Holder: _____

Policy ID Number: _____

VR Goal Related? Yes ☐ No ☐ VR Employment Objective _____

Test Results attached? Yes ☐ No ☐ Number of pages attached: _____

Referral Source:

Counselor ☐ Voc. Evaluator ☐ Case Mgr ☐

Employment Specialist ☐ Therapist ☐ Other ☐ *specify* _____

Name: Last _____ First _____

Organization represented _____

Street Address (or PO Box) _____

City _____ State _____ Zip _____

Phone (w) _____ (Fax) _____ E-mail _____

Objective: *Please briefly state the current status and desired outcomes of assistive technology*

Computer Accommodation Lab Services Requested: ***(send form to CAL Engineer)***

Equipment Evaluation ☐ Equipment Setup ☐ Adaptive Computer Interface ☐

Troubleshoot/Repair ☐ Loaner Computer ☐ Other *(explain below)* ☐

Occupational Therapy Services Requested: ***(send form to DRS Occupational Therapist)***

Ergo, Computer/Work Site Eval. ☐ Home Mod, ADL/Safety ☐ Seating, positioning ☐

Other ☐ (*explain)* _____

Rehab Engineering Services Requested ***(send form to Rehabilitation Engineer)***

Work Site Eval ☐ Home Mod Eval ☐ >> Does Client own dwelling? Yes ☐ No ☐

Equip Design, Mod, Fabrication ☐ Vehicle Mod Eval ☐ Other ☐ *(explain below)*

Directions (MUST BE ATTACHED) to: Work ☐ Home ☐ School ☐